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PREAMBLE

The Eugene Talmadge Memorial Hospital, located in Augusta, Georgia opened in 1956 to serve as the primary teaching hospital of the Georgia Regents University, Medical College of Georgia. Since that time it has emerged as a major health science center and is now known as the Georgia Regents Medical Center operated by MCG Health, Inc.AU Medical Center is a cooperative organization of the Board of Regents of the University System of Georgia. The ultimate administrative authority and responsibility for the Georgia Regents Medical Center resides with the Board of Directors of MCG Health, Inc.AU Medical Center.

Children’s Hospital of Georgia operated by AU Medical Center MCG Health, Inc. is a facility established for and dedicated primarily to the care of infants, children and adolescents. AU Medical Center MCG Health, Inc. is a cooperative organization of the Board of Regents of the University System of Georgia. The ultimate administrative authority and responsibility for the Children’s Hospital of Georgia resides with the Board of Directors of AU Medical Center MCG Health, Inc.

The Medical Staff has primary responsibility for the quality of the professional services provided by individuals with clinical privileges in Georgia Regents Medical Center and the Children’s Hospital of Georgia and is accountable to the Board of Directors. The physicians, dentists, and other practitioners of the Georgia Regents Medical Center and the Children’s Hospital of Georgia hereby organize themselves in conformity with the Bylaws and Rules and Regulations hereinafter stated. These Bylaws, Rules and Regulations and supporting Policies and Procedures create a framework for governance of Medical Staff activities and accountability to the Board of Directors within which Medical Staff members can act with a reasonable degree of freedom and confidence and will ensure Medical Staff representation and participation in any Georgia Regents Medical Center and/or the Children’s Hospital of Georgia deliberation affecting the discharge of staff responsibilities.

ORGANIZATION

The Medical Staff of AU Medical Center MCG Health, Inc. shall operate under the guidance and direction of the AU Medical Center MCG Health, Inc. Board of Directors, Chief Medical Officer, the Medical Staff Bylaws, which create a governance framework.

The day-to-day management of Medical Staff issues within the Georgia Regents Medical Center and Children’s Hospital of Georgia shall be conducted by the Medical Staff that has a President elected by a majority of medical staff members credentialed, manage a Credentials Committee and Medical Executive Committee. The Medical Staff supported by credentialed medical staff members.

ARTICLE I - DEFINITIONS

1. Board of Directors means the Board of Directors of MCGHAUMC, which is the governing body of this organization.
2. Chief Medical Officer means the Chief Medical Officer of MCGHAUMC.
3. Georgia Regents Medical Center means Georgia Regents Medical Center and includes all programs that are covered by MCGHAUMC.
4. Children’s Hospital of Georgia means MCGH’s AUMCs Children’s Medical Center and includes all pediatric programs.
5. Clinical Privileges means authorization granted by the Board of Directors to a Practitioner to provide specific patient care services in Georgia Regents Medical Center and Children’s Hospital of Georgia and Georgia Regents University (GRU)/MCGHAUMC/Georgia Regents AU Medical Associates (GRMAUMA)-administered off-site clinical care facilities within defined limits.
6. Contracted Physician or Dentist means a physician or dentist who is not a member of the Medical Staff, but who is granted Clinical Privileges and practices at Georgia Regents Medical Center and Children’s Hospital of Georgia pursuant to a contract between the individual or some other third

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party and MCGHAUMC, other than the contract between MCGHAUMC and GRMA-AUMA dated as of July 1, 2000 and any modification, extension or renewal thereof. A Contracted Physician or Dentist shall not include a Locum Tenens.

7. Credentialing means the process of obtaining, verifying through primary sources, and assessing the qualifications of a Practitioner to provide patient care services in or for Georgia Regents AU Medical Center and Children’s Hospital of Georgia, GRU Augusta University/MCGHAUMC/GRMA-AUMA-administered off-site clinical care facilities.

8. Dean of the GRU Augusta University-Medical College of Georgia means the Dean of the GRU Augusta University-Medical College of Georgia.

9. DOAS means the Georgia Department of Administrative Services.

10. Executive Committee means the executive committee of the Medical Staff.

11. Faculty or Faculty Member means an individual who holds an academic faculty appointment at GRU Augusta University whether or not such individual is an employee of Augusta University/GRU, which includes full time faculty, part time faculty and clinical faculty.

12. Practitioner means any individual permitted by law to provide patient care services without direction or supervision, within the individual’s license. This includes, but is not limited to physicians, dentists, psychologists, optometrists, and podiatrists.

13. Locum Tenens means a physician or dentist who is not an active member of the Medical Staff, but who is granted Courtesy Clinical Privileges pursuant to Article V, Section 4 of these Bylaws.

14. GRU Augusta University-School of Medicine means the Georgia Regents University.

15. MCGHI-AUMC means the nonprofit corporation, MCG Health, Inc AU Medical Center established under the laws of the State of Georgia.

16. Medical Staff means the medical staff of Georgia Regents Augusta University, and Children’s Hospital of Georgia as provided for in these bylaws.

17. GRMA-AUMA means MCG Georgia Regents AU Medical Associates Foundation.

18. President/CEO means the President and Chief Executive Officer of MCGHAUMC.

19. Privileging means the process, as described in these Bylaws and the Rules and Regulations by which Clinical Privileges are granted to each Practitioner who is entitled to perform those Clinical Privileges at Georgia- AU Regents-Medical Center, Children’s Hospital of Georgia, and GRU Augusta University/MCGHAUMC/GRMA-AUMA-administered off-site clinical care facilities.

20. Rules and Regulations means any and all rules, regulations, policies and procedures of the Medical Staff adopted as provided for herein.

21. Service Chief means the Medical Staff chief of each of the clinical services described in Article VIII hereof who has responsibility for directorship of that particular clinical service.

22. The use of only a masculine or feminine pronoun or suffix refers to men and women and is used for the sake of brevity unless the context clearly indicates otherwise.

23. All officers of the medical staff may designate appropriately qualified members of the medical staff to act in their stead when they are not available. If a designee attends a meeting of the Medical Executive Committee, their participation may require approval by a vote of the Medical Executive Committee.

ARTICLE II - NAME

The name of this organization shall be the "Medical Staff of MCG Health, Inc AU Medical Center."

ARTICLE III - PURPOSE

The purpose of the Medical Staff shall be:

1. To have primary responsibility for the quality of patient care provided by individuals with Clinical Privileges which includes without limitation the responsibility of accounting for performance to the Board of Directors to ensure and improve the quality of the professional services provided by individuals with Clinical Privileges.
2. To provide a mechanism for governance of the Medical Staff, the credentialing process, the 
advising of the Board of Directors and the structures necessary for the ongoing activities of the 
Medical Staff which support continuous improvement in the quality and appropriateness of patient 
care.

3. To formulate recommendations on amendments to these Bylaws, and the amendment or 
establishment of Rules and Regulations necessary or desirable for the rendering of high quality 
professional patient care services, and to communicate these recommendations through the 
Medical Executive Committees and the Board of Directors.

4. To advise and educate the members of the Medical Staff and all others with Clinical Privileges of 
the provisions of these Bylaws and the Rules and Regulations, and to enforce and follow these 
Bylaws and the Rules and Regulations for the direction and governance of the Medical Staff, to 
ensure all Medical Staff members and all others with Clinical Privileges are subject to these Bylaws, 
and the Rules and Regulations to review these Bylaws and Rules and Regulations, as part of the 
performance improvement activities.

5. To create a system of mutual rights and responsibilities between members of the Medical Staff and 
MCGHI AUMC, which supports and enhances a patient/family-centered clinical environment in 
support of Georgia RegentsAU Medical Center and Children’s Hospital of Georgia, and MCGHI 
AUMC goals of patient care, education and research.

6. To outline a method for effective communication among Medical Staff, MCGHI AUMC 
administration and the Board of Directors regarding all policy decisions affecting patient care 
services in Georgia RegentsAU Medical Center and Children’s Hospital of Georgia.

7. To develop and implement criteria for the supervision and education of physicians in training and 
to ensure that the responsibilities as outlined in the Rules and Regulations and appropriate policies 
are consistent with standards established by the Accreditation Council for Graduate Medical 
education and the appropriate Residency Review Committee.

8. To promote the advancement of new medical knowledge through the support of health science 
research.

All of the foregoing purposes shall be carried out with the recognition that the Medical Staff is a part 
of MCGHI AUMC and a participant in the functioning of Georgia RegentsAU Medical Center and/or 
Children’s Hospital of Georgia and that the Board of Directors has the ultimate responsibility for the 
operation of both.

ARTICLE IV - MEMBERSHIP

Section 1. Qualifications of Membership

a. In order to be qualified for and to remain qualified for membership on the Medical Staff, applicants 
and members of the Medical Staff must have the following qualifications:

1. An M.D., D.O., D.D.S., D.M.D. or equivalent degree from an accredited medical or dental 
school;

2. A license to practice medicine or dentistry in the State of Georgia, except that such may 
not be required for physician or dentist on active duty in the U.S. military provided such 
physician or dentist has a current license from another state:
3. Capability and desire to use Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia as part of his or her practice. As a general rule membership will be limited to those practitioners whose principle medical practice is located within 30 miles of the GRU-Augusta University campus. However, exceptions may be authorized by the Clinical Service Chief or Chief Medical Officer where services offered will be enhanced healthcare delivery to the patients of Georgia Regents AU Medical Center and Children’s Hospital of Georgia, GRU-Augusta University/AUC/GRIA/AUMC-administered off-site clinical care facilities;

4. Physical and mental health sufficient to carry out the Clinical Privileges requested as delineated in the Medical Staff Credentialing Policy 13.51.

5. Necessary background, experience, training and demonstrated competence to assure, in the judgment of the Board of Directors, that any patient admitted to or treated in the Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia will be given appropriate care.

6. Willingness to participate in the teaching program.

7. Contracted Physicians/Dentists and Locum Tenens shall be eligible for only Courtesy membership on the Medical Staff.

8. MCG Health, Inc. AU Medical Center may not employ or contract with providers excluded from participation in Federal health care programs.

b. No applicant shall be denied membership on the Medical Staff on the basis of sex, race, color, creed, religion or national origin.

c. No applicant shall be appointed to the Medical Staff and no member of the Medical Staff shall be allowed to remain a member of the Medical Staff unless such person acquires and maintains medical professional liability insurance satisfactory to MCGHI AU MC in compliance with the Medical Staff Credentialing Policy 13.51 as to professional liability insurance limits.

d. A physician or dentist who applies for membership to the Courtesy Medical Staff shall be a member of the active category of a medical staff of another hospital where he or she is subject to quality assessment activities. At the discretion of the Executive Committee and the Board of Directors, this requirement may be waived for a physician or dentist who engages in a type of practice that by its nature would not normally allow such physician or dentist to qualify for membership in the active category of the medical staff of another hospital, provided that the appropriate Executive Committee and the Board of Directors are satisfied that such physician or dentist meets all other requirements for membership on the Courtesy Medical Staff.

e. Each practitioner who applies for appointment to the Medical Staff shall, at a minimum, provide information regarding previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, whether temporary or permanent, and all professional liability experience. Any member of the Medical Staff shall report any challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, whether temporary or permanent, and all professional liability experience to the Credentials Committee within 30 days of the occurrence. The practitioner shall report any claims, lawsuits or other civil actions or proceedings of any nature as well as all settlements, final judgments or other disposition of any such claim, lawsuit or other civil action or proceeding to the Credentials Committee within 30 days of the occurrence.
Section 2. Ethics

The professional conduct of the Medical Staff shall comply with generally accepted principles of professional ethics including but not limited to the MCGHI/AUMC values, the code of ethics adopted by Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia and the code of ethics promulgated by each practitioner’s group such as the American Medical Association, the American Dental Association, and specialty and subspecialty society codes of ethics. Members of the Medical Staff shall conduct all of their activities within Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia in accordance with all federal, state and local laws, rules and regulations, and shall uphold the dignity and honor of the medical profession, Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia. Members of the Medical Staff will be required to complete and sign a conflict of interest disclosure statement annually.

Section 3. Terms of Appointment/Reappointment

Subsection 1. Appointment to membership on the Medical Staff shall be made by the Board of Directors upon recommendation of the Executive Committee acting for the Medical Staff.

Subsection 2. Appointment to membership on the Medical Staff shall confer on the appointee only such privileges as have been granted by the Board of Directors in accordance with these Bylaws and the Rules and Regulations and shall be subject to all terms and conditions hereof and thereof.

Subsection 3. Initial appointments and Clinical Privileges shall be Provisional for a period of one year. At the end of the Provisional period the performance of the person shall be reviewed by the Clinical Service Chief and recommendations made to the Credentials Committee. The Credentials Committee shall then make recommendations to the Medical Executive Committee which then makes recommendations to the Board of Directors. The Board of Directors may terminate the provisional status and extend the person’s Medical Staff membership and Clinical Privileges for an additional year, may extend the provisional status for an additional period of up to one year or terminate the persons Medical Staff membership and Clinical Privileges. With the exception of the Clinical Service Chiefs and Chief Medical Officer, Provisional members of the medical staff may not vote or hold office.

Subsection 4. Reappointments to the Medical Staff and re-confering of Clinical Privileges shall be for two-year periods. Expiration dates of reappointments may be staggered in accordance with the Medical Staff Credentialing Policy.

Section 4. Procedure for Appointment/Reappointment

Subsection 1. The process for appointment to the Medical Staff membership and for initial Clinical Privileges shall be as set forth in the Medical Staff Credentialing Policy for initial appointment and initial granting of privileges. Action on an application for appointment to the Medical Staff should be completed within 180 days from the application being deemed complete as set forth in the Medical Staff Credentialing Policy subject to longer times as may result from an unusual situation or appeals of an adverse professional review recommendation pursuant to Article VI hereof.

Subsection 2. The process for reappointment to Medical Staff membership and for extension of Clinical Privileges shall be as set forth in the Medical Staff Credentialing Policy for Reappointment and renewal or revision of clinical privileges. The action on an application for reappointment to the Medical Staff should be completed within 180 days of the application begin deemed complete as set forth in the Medical Staff Credentialing Policy. Longer times may result from an unusual situation, military deployment, or appeals of an adverse professional review recommendation pursuant to Article VI hereof.
Subsection 3. Failure to complete action on an application for appointment or reappointment to the Medical Staff as set forth in Subsections 1 and 2 of this Section 4 shall create any liability on the part of MCGHAUMC, the Medical Staff, its members or committees nor shall it create any additional rights on the part of the applicant.

Section 5. Obligations of Medical Staff Members

Each member of the Medical Staff shall be obligated to carry out all of his or her professional responsibilities including but not limited to the following:

a. Care of the patient is the responsibility of the physician in whose name the patient has been admitted or to whom the patient has been transferred.

b. Each member of the Medical Staff is responsible for providing for continuous care for his patients; this responsibility may be carried out by providing appropriately privileged professional coverage when the responsible physician is unavailable.

c. Appropriate communication between all caregivers and coordination of the patient’s care, treatment and services is the responsibility of the patient’s attending physician.

d. If a patient’s condition requires care, procedures or expertise for which the practitioner is not privileged or educated, consultation with appropriately privileged practitioner must occur or the patient care must be transferred to another appropriately privileged practitioner.

e. The patient’s rights shall be respected and observed in all instances by the members of the Medical Staff.

f. Each physician shall conduct himself in a professional and appropriate manner to enhance the care of the patients and shall not engage in disruptive or disrespectful behavior towards patients, hospital staff, visitors, trainees, or other Medical Staff members.

g. Appropriate supervision will be provided for physicians in training involved in the care of patients as defined in the Rules and Regulations and appropriate policies.

h. Notification will be provided by physicians to the Medical Staff Office of any change in their supervision of physician assistants within 30 days.

i. Document their commitment to abide by the Bylaws, Rules and Regulations, and Policies of the Medical Staff and of the Hospital, including policies regarding the privacy, confidentiality, and security of protected health information.

j. A member of the Medical Staff who is or may be unable to practice with reasonable skill and safety, regardless of the reason, shall be evaluated in accordance with relevant Medical Staff policies and procedures.

k. Staff appointments may be revoked or limited for due cause, including but not limited to physical or mental disability, impairment (regardless of cause), failure to
provide adequate patient care, or failure to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff or MCGHAUMC, including approved policies of Departments, Sections and Committees.

i. The President/CEO, Chief Medical Officer, President of the Medical Staff, or their designees, may request that a member of the Medical Staff undergo drug or alcohol testing, in accordance with MCG-Health, Inc., AU Medical Center Human Resources Substance Abuse Policy. This policy applies to all Medical Staff, Allied Health Professionals, and other clinical staff providing services to patients or employees while on MCGHAUMC property.

m. The requirements for appropriate admissions to the hospital as outlined in the Medical Staff Rules and Regulations, including but not limited to the requirements for the History and Physical for patients.

ARTICLE V - CLINICAL PRIVILEGES

Section 1. Granting of Clinical Privileges

Subsection 1. Members of the Medical Staff and such other Practitioners as approved by the Board of Directors to provide patient care services independently may be granted Clinical Privileges, which must be delineated and described clearly and concisely. Except as otherwise herein provided, Clinical Privileges may be granted only upon recommendation of the Executive Committee and approved by the Board of Directors. Privileging shall be as set forth in the Rules and Regulations therefore.

Subsection 2. Courtesy Membership to the Medical Staff may be granted to Contract Physician/Dentist and Locum Tenens only if the following conditions are met and maintained:

a. If the applicant is a physician or dentist, he/she must have an M.D., D.O., D.D.S., and D.M.D. or equivalent degree from an accredited medical or dental school, or if the applicant is another type of patient care provider he/she must have the requisite degree for the services being provided from an accredited school offering such degree;

b. The applicant must have a current license from the State of Georgia to provide the patient care services being provided, or be subject to the limited exception in Article IV., Section 1.a.2.;

c. The applicant must have physical and mental health sufficient to carry out the Clinical Privileges requested;

d. The applicant must have the necessary background, experience, training and demonstrated competence to assure in the judgment of the Board of Directors that any patient treated at Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia will be given appropriate care;

e. The applicant shall have and keep in force professional liability insurance satisfactory to MCGHAUMC in compliance with Medical Staff Credentialing Policy as to professional liability insurance limits. The applicant must provide a certificate of insurance evidencing such coverage and upon each renewal of such policy as long as Clinical Privileges are maintained;
f. Each applicant shall in his/her professional conduct comply with generally accepted principles of professional ethics including but not limited to the MCGHI AUMC values, the code of ethics adopted by MCGHI-AUMC and the code of conduct promulgated by the state and national professional associations for the professional services provided by the applicant. The applicant shall conduct all of his/her activities at Georgia Regents Medical Center and/or the Children’s Hospital of Georgia in accordance with all federal, state and local laws, rules and regulations and shall uphold the dignity and honor of his/her profession., Georgia Regents Medical Center and/or the Children’s Hospital of Georgia.

g. The applicant shall agree by the acceptance of Clinical Privileges to exercise the same in accordance with provisions of these Bylaws or the Rules and Regulations and to be subject to the corrective actions and disciplinary procedures set forth in these Bylaws. The applicant shall acknowledge that although not an Active member of the Medical Staff he/she is subject to the provisions hereof in furtherance of the Medical Staffs obligation to be primarily responsible for the quality of patient care provided at Georgia Regents Medical Center and/or the Children’s Hospital of Georgia.

Section 2. Determination of Privileges

Subsection 1. Each clinical service shall recommend to the Executive Committee the Clinical Privileges to be exercised within that clinical service and the criteria for granting such Clinical Privileges. These Clinical Privileges shall be based upon generally accepted criteria for professional practice and applicable standards of care, and shall include telemedicine privileges and GRU Augusta University/MCGHIAUMC/GRMAUU/MAUHU-administered off-site clinical care facilities when appropriate and approved by the Clinical Service Chief. The Executive Committee, after reviewing such requests, shall make a recommendation to the Board of Directors for its consideration and approval. No Clinical Privilege shall be granted without approval of the Board of Directors.

Subsection 2. Determination of Clinical Privileges at the time of initial appointment to the Medical Staff or when requested as an additional privilege by one who already has some Clinical Privileges shall be based upon an applicant’s training, experience, health status, current licensure, peer review, clinical practice logs per Credentialing Policy, and demonstrated competence documented through primary source verification.

Subsection 3. Determination of extension of Clinical Privileges shall be based upon an applicant’s training, experience, health status, current licensure, clinical practice logs per Credentialing Policy, and demonstrated competence, which are evaluated by review of the applicant’s credentials, including a review of professional liability experience, and by primary source verification and observation by appropriate Active Medical Staff members, and by review of reports of the Performance Improvement Committee, as provided in these Bylaws, and based on a recommendation by the Service Chief(s). Professional liability experience shall include all claims, lawsuits or other civil actions or proceedings of any nature that allege professional negligence or malfeasance as well as all settlements, final judgments or other disposition of any such claim, lawsuit or other civil action or proceeding.

Subsection 4. At least every two years, which for members of the Medical Staff shall be at the time of their reappointment application, Clinical Privileges shall expire. There shall be a review of the Clinical Privileges by the Credentials Committee for each member of the Medical Staff and each Practitioner with Clinical Privileges before the Clinical Privileges may be extended. At the time of the review the applicant’s training, experience, health status, current licensure, clinical practice logs per Credentialing Policy, and demonstrated competence will be assessed. The Service Chief shall
make a recommendation on the extension of Clinical Privileges to the appropriate Credentials Committee based on specific performance improvement data. Each Service Chief shall develop mechanisms for internal review of Clinical Privileges and be responsible for providing recommendations on whether to extend the specific Clinical Privileges held by the applicant.

**Subsection 5.** Clinical Privileges may be granted for less than two-year periods as follows:

a. The initial granting of Clinical Privileges shall be provisional for a period of one year or the total term for which the Clinical Privileges are granted whichever is shorter. At the end of the provisional period the performance of the person shall be reviewed by the Clinical Service Chief and recommendation made to the Credentials Committee. The Credentials Committee shall then make recommendations to the Medical Executive Committee which then makes recommendations to the Board of Directors. The Board of Directors may terminate the provisional status and extend the Clinical Privileges for an additional period of up to one year, may extend the provisional status for an additional period of up to one year or terminate the Clinical Privileges.

b. The Clinical Privileges of a Contracted Physician or Dentist or any other Practitioner providing services under a contract between him/her or another third party and MCG Health shall automatically terminate upon the termination of such contract or upon the holder of the Clinical Privileges ceasing to be a provider of services under such contract.

c. Temporary Clinical Privileges shall not be granted for more than sixty (60) days, and may be extended for one additional period of not more than sixty (60) days and only as provided for in the Medical Staff Credentialing Policy.

d. Clinical Privileges granted to active duty military physicians and dentists with clinical care assignments in Georgia Regents Medical Center and/or the Children’s Hospital of Georgia shall automatically terminate upon the termination of such person’s clinical care assignment to Georgia Regents Medical Center and/or the Children’s Hospital of Georgia.

e. As elsewhere as provided in these Bylaws.

**Section 3. Emergency Privileges**

In case of an emergency, which is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger, any physician or dentist to the degree permitted by his license and regardless of clinical service or staff status or lack of it, shall be permitted and assisted in doing everything possible to prevent serious permanent harm or to save the life of the patient, using such resources of Georgia Regents Medical Center and/or the Children’s Hospital of Georgia as may be necessary and any consultation necessary or desirable. When an emergency situation no longer exists, such physician or dentist must request the Clinical Privileges necessary to continue to treat the patient. In the event such Clinical Privileges are denied or the physician or dentist does not desire to request Clinical Privileges, following consultation with the patient and/or his family, the patient shall be assigned by the Chief Medical Officer or designee to the care of another member of the Medical Staff.

**Section 4. Disaster Privileges**

When the Emergency Operation Plan (EOP) has been activated for a local, state or national disaster, and the Chief Executive Officer or designee has declared, in writing, that MCG Health.
In AU Medical Center is operating in a disaster mode (not emergency mode), disaster privileging can be authorized by the Chief Medical Officer when the Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia is unable to handle the immediate patient care needs. Disaster privileges must be granted prior to providing patient care, even in a disaster situation, and decisions are made on a case-by-case basis at the discretion of the Medical Directors. The practitioner will be assigned to an appropriate service on the MCGHIAUMC Medical Staff in which he/she is granted disaster privileges and the Clinical Service Chief or designee will be responsible for managing the activities of the practitioner. Disaster privileges do not confer any status on the medical staff to which the practitioner is assigned.

Section 5. Temporary Privileges

Temporary privileges may be granted by the President/CEO or in his/her absence the Chief Medical Officer (or designee), to a Practitioner: (1) upon the written request of the Service Chief, or the President of the Medical Staff, with the subsequent approval of the Chief Medical Officer to provide specialized care to a specific patient or (2) on recommendation of the Credentials Committee, to allow an applicant with a totally complete application as defined by the Medical Staff Credentialing Policy and reviewed and approved without reservations by two committee members to begin practice pending review and approval of the Medical Executive Committee and Board of Directors. The authority to grant these temporary privileges is delegated by the Board of Directors and may be granted only if (1) the MCGHIAUMC Medical Staff Office has received a written request from the Service Chief for specific privileges, and has, through primary source verification, confirmed those items as noted in the Medical Staff Credentialing Policy; (2) signature approval has been obtained from the Service Chief and either the Chief Medical Officer, or the President of the Medical Staff, and (3) grantee agrees to serve under the supervision of the Service Chief or Chief Medical Officer or other such supervision as deemed appropriate. Temporary privileges shall be granted for a limited period of time not to exceed sixty (60) days, and may be extended for one additional period of not more than sixty (60) days. The President/CEO or his/her designee must send a letter to the applicant delineating Clinical Privileges stating the duration thereof and informing the applicant that he/she is not appointed to Active membership on the Medical Staff and is not entitled to vote or hold office. A list of all members who have practiced under temporary privileges in the previous 30 days will be reviewed at each Credentials Committee meeting.

Section 6. Summary Suspension, Termination, Leave of Absence, Inactive Status

Section 6.1 --Initiation of Summary Suspension or Termination. Whenever there are reasonable grounds to believe that the conduct or activities of a Medical Staff Member pose a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the President of the Medical Staff, the Chief Medical Officer, the Chair of any department with respect to physicians in that department, the Executive Committee, the President/Chief Executive Officer and the Board of Directors shall each have the authority to summarily suspend or restrict all or any portion of the Medical Staff Member’s clinical privileges. Within 72 hours of rendering a Summary Suspension the Chief Medical Officer, and Service Chief must determine if a Corrective Action should be initiated in accordance with Section 1 of Article VI.

The Medical Center may deny access to any student, housestaff or faculty when, in the sole opinion of the Medical Center, the student, housestaff or faculty is deemed to be a risk to the Medical Center’s patients or themselves. The Medical Center will notify the student’s school within twenty-four (24) hours of denying access to any student, housestaff or faculty, and then will cooperate with the school’s investigation of the denial of access.

Section 6.2 -- Events Resulting In Automatic Termination. An appointment to the
Medical Staff, as well as all clinical privileges, shall be automatically terminated upon the occurrence of any of the following events:

(i) A Medical Staff Member shall lose his or her license to practice his or her profession, or a restriction or condition of any sort shall be placed upon such license; provided, however, that the placing of an Appointee on probation by the Georgia Composite Medical Board and the imposition of only the standard conditions uniformly applied to all physicians then being placed on probation by the Georgia Composite Medical Board shall not be the basis for automatic termination alone without the imposition of restrictions or conditions which in some way restrict the Appointee’s license or ability to practice medicine or to treat patients. However, the imposition by the Georgia Composite Medical Board of any restriction or condition shall give rise to an ad hoc investigation pursuant to Section 1 of Article VI.

(ii) A Medical Staff Member fails to report to the Medical Staff any restriction or condition imposed on or probation with respect to his or her license by the Licensure Board within thirty (30) days of the imposition of such restriction, condition or probation.

(iii) A Medical Staff Member has his or her right to prescribe or administer any controlled substances revoked or suspended in any manner.

(iv) A Medical Staff Member has his or her right to bill Medicare, Medicaid, or any other federal or state healthcare program revoked or suspended in any manner.

(v) A Medical Staff Member has his or her name placed on any list of providers excluded from billing Medicare, Medicaid, or any other federal or state healthcare program.

(vi) A Medical Staff Member, after warning, shall fail to complete medical records in a timely fashion pursuant to the Rules and Regulations of the Medical Staff.

(vii) A Medical Staff Member shall fail to maintain the minimum professional liability insurance coverage established from time to time as required by the Medical Staff Bylaws, unless the Medical Staff Appointee has timely requested a waiver or reduction of such coverage and is awaiting final action on such request.

Section 6.3 — Leave of Absence. A Medical Staff Member may request a leave of absence for a period of up to one (1) year for health, education, or military deployment.

Section 6.4 — Inactive Status If the medical professional liability coverage or licensure of a Medical Staff Member as required by Medical Staff Credentialing Policy is allowed to lapse, expire, is canceled or for any other reason ceases to be in effect and is not immediately replaced by other coverage or licensure meeting the requirements of the Medical Staff Credentialing Policy, such member of the Medical Staff shall automatically be considered to be on an inactive status from membership on the Medical Staff (if applicable) and his/her Clinical Privileges shall be automatically inactivated. The Chief Medical Officer shall provide written notice of inactivation to the practitioner immediately. Evidence of the replacement insurance coverage or licensure will be presented to the President/CEO in order to be reactivated. Failure to provide documentation of insurance coverage or licensure within six (6) weeks of the inactivation will be considered voluntary resignation from the Medical Staff.

Section 6.5 — Resumption of Suspended Clinical Privileges

A. In those situations where a Practitioner has relinquished all or part of his/her clinical privileges to provide patient care the Practitioner may submit a written request to the Credentials Committee asking for a reinstatement of his/her clinical privileges. If the Credentials Committee is satisfied that the Practitioner is in good recovery and capable of resuming care of patients, without a threat to the safety of the patients, the Committee shall report this to the Medical Executive Committee, and may recommend the following among other things to the Medical Executive Committee.

1. That the Practitioner’s Clinical Service / Clinical Service Chief assume responsibility for the care of his/her patients in the event of the Practitioner’s inability or unavailability;
2. A mechanism to show whether the Practitioner is continuing to participate in the recovery program, which may include, among other things, periodic unannounced drug screens and/or participation in specified counseling or recovery group meetings;

3. That the Practitioner be required to provide periodic reports sent directly to the Credentials Committee and/or the Chief Medical Officer from his/her monitoring physician for a period of time specified by the Medical Executive Committee.

4. That the Practitioner enter into an agreement covering his/her resumption of clinical privileges and will provide that failure to comply with its terms may result in immediate suspension of all clinical privileges; and

5. That the Practitioner’s exercise of clinical privileges shall be monitored as specified by the Medical Executive Committee through a Focused Professional Performance Evaluation (FPPE).

B. Reinstatement of clinical privileges shall be subject to approval by the Board of Directors of MCG Health, Inc. AU Medical Center upon recommendation by the Medical Executive Committee.

Section 7. Automatic Revocation of Medical Staff Membership and Clinical Privileges

If the license to practice of a Medical Staff member is suspended or revoked by the Georgia Composite Medical Board, or by the Georgia Board of Dentistry or by another applicable State of Georgia licensing board or authority or if a Medical Staff Member’s Drug Enforcement Agency (DEA) registration is suspended or revoked, the Medical Staff membership of such person shall automatically be revoked and terminated. Such person shall not be allowed to resume membership on the Medical Staff or have Clinical Privileges at Georgia Regents AU Medical Center without obtaining appointment to the Medical Staff as a new applicant.

ARTICLE VI - CORRECTIVE ACTION, HEARINGS AND APPEALS PROCEDURE

Section 1. Corrective Action

Section 1.1 -- Initiating a Corrective Action. Whenever it appears that corrective action against a Medical Staff Member may be necessary or advisable an investigation by an ad hoc investigation committee should be requested. Requests for corrective action may be initiated by the President/Chief Executive Officer, the President of the Medical Staff, by any other officer of the Medical Staff, by the Service Chief of any department, by the Chairman of any committee of the Medical Staff, the Chief Medical Officer, or by any member of the Board of Directors. Any request for corrective action shall be in writing and shall be submitted to the Credentials Committee, together with detailed information concerning the specific activities or conduct which constitutes the grounds for the request. Credentials Committee may consult with the President of the Staff, the appropriate Service Chief, the Chief Medical Officer, or the appropriate Executive Committee to determine whether the request for corrective action should be investigated. The initiation of an investigation shall not preclude the imposition of summary suspension under Section 2 of this Article VI.

Section 1.2 -- Appointment of Ad Hoc Investigation Committee. If the Credentials Committee determines to investigate the necessity or advisability of corrective action against a particular Medical Staff member as the result of an informal investigation or otherwise, an Ad Hoc Investigation Committee shall be appointed. In addition, an Ad Hoc Investigation Committee shall be appointed to investigate a Medical Staff member any time the Georgia Composite Medical Board places a restriction or limitation of any sort on such Medical Staff Member’s license or places such Medical Staff Member on probation,
unless the action of the Georgia Composite Medical Board has resulted in automatic
termination of the appointment of the Medical Staff Member. It is the explicit intention of
the Medical Staff that the Ad Hoc Investigation Committee shall consist of the Chief
Medical Officer (or his or her designee), two (2) Medical Staff members appointed by the
applicable Credentials Committee and two (2) Medical Staff Appointees appointed by
Service Chief. The Chief Medical Officer (or his or her designee) shall serve as
Chairperson of the Ad Hoc Investigation Committee. The Ad Hoc Investigation
Committee shall have no voting members who are in direct economic competition with
the Medical Staff Member who is the subject of the investigation. In the event there are
not a sufficient number of Medical Staff Members who meet such criteria, the Chief
Medical Officer may appoint physicians who are not affiliated with the Medical Staff who
meet such criteria. The Medical Staff Member shall be advised of the names of the Ad
Hoc Investigation Committee members within ten (10) days of the appointment of such
Ad Hoc Investigation Committee. If the Medical Staff Member who is the subject of the
investigation advises the Chief Medical Officer that he or she believes a member of the
Ad Hoc Investigation Committee does not meet this criterion, the Chief Medical Officer
shall determine the merit of such contention and, if the contention is found to be correct,
shall appoint a substitute to serve on the Ad Hoc Investigation Committee. An
investigation by an Ad Hoc Investigation Committee shall be considered an administrative
matter and not an adversarial proceeding. A Medical Staff Member who is the subject of
an investigation shall not be entitled to have legal counsel present during any meetings or
discussions between such Medical Staff Appointee and members of an Ad Hoc
Investigation Committee. Testimony and documentary evidence may be considered
informally at the ad hoc investigation stage, but must be verified under oath at any
subsequent hearing, to be considered.

Section 1.3 --- Preliminary Report of Ad Hoc Investigation Committee. Upon conclusion
of its investigation, the Ad Hoc Investigation Committee shall submit a preliminary report
in writing to the Credentials Committee and to the affected Medical Staff Member. Such
report shall contain a statement detailing the preliminary findings, conclusions and
recommendations of the ad hoc investigation committee. The Credentials Committee
and the affected Medical Staff Member shall be given the opportunity to submit
comments on the preliminary report of the Ad Hoc Investigation Committee within fifteen
(15) days following receipt of the preliminary report.

Section 1.4 --- Procedure After Report of Ad Hoc Investigation Committee. The report of
the Ad Hoc Investigation Committee shall be forwarded to the Executive Committee with
any written comments by the affected medical staff member. If the Ad Hoc Investigation
Committee has made a proposal to recommend an action for which a hearing right is
required under Section 3 of the Fair Hearing Procedure, then the affected Medical Staff
Member shall be entitled to the procedural rights set forth in the Fair Hearing Procedure
before final action is taken by the Board of Directors. If a hearing is requested and the
Hearing Committee or, upon appeal, the Ad Hoc Appeals Committee recommends a
decision in accordance with the proposed recommendation of the Ad Hoc Investigation
Committee, then the proposed recommendation shall be deemed to have been made,
and the Board of Directors shall make the final decision in accordance with the provisions
of the Hearing Procedure. If the right to hearing is waived, then the Board of Directors
shall be notified that the proposed recommendation of the Ad Hoc Investigation
Committee is a final recommendation of such Committee, and the Board of Directors
shall take final action after reviewing the report of the Committee. If the Ad Hoc
Investigation Committee does not propose to recommend any action as to which a
hearing right is required under the Fair Hearing Procedure, then the Committee’s report
and its recommendation shall be forwarded to the Board of Directors for final action.
Section 2. Right to Hearing

Section 2.1 -- Right to One Hearing. No Applicant or Medical Staff Member shall be entitled as a matter of right to more than one (1) hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right.

Section 2.2 -- Right to Hearing. Unless waived, an Applicant or Medical Staff Member shall be entitled to a hearing if any professional review body proposes (i) to make a recommendation that any of the following adverse actions be taken with respect to him or her for reasons other than failure to meet minimum objective criteria specified in the Medical Staff Bylaws or Appointment and Corrective Action Procedures, or (ii) to take any of the following adverse actions without a prior adverse recommendation of any professional review body for reasons other than failure to meet minimum objective criteria specified in the Medical Staff Bylaws or Appointment and Corrective Action Procedures:

(i) Denial of a completed application for initial appointment or reappointment to the medical staff for any reason, except where: (i) the application does not meet the minimum objective requirements set forth in the Medical Staff Bylaws or Appointment and Corrective Action Procedures; or (ii) the applicant is requesting clinical privileges in a department, subspecialty or service in which the number of Medical Staff Appointees has been limited in accordance with the Medical Staff Bylaws.

(ii) Summary suspension or termination of clinical privileges in accordance with the Corrective Action Procedures.

(iii) Revocation or termination of appointment to the medical staff, except where continued appointment to the medical staff was contingent upon the continuance of a contractual relationship with the healthcare entity.

(iv) Denial of requested advancement or requested change in medical staff category, except for any denial resulting from failure to meet the minimum objective criteria for the requested category.

(v) Denial of requested advancement or requested change in Medical Staff category, except for any denial resulting from a failure to meet the minimum objective criteria for the requested category.

(vi) Reduction in Medical Staff category, other than (i) a change from Active Medical Staff to Courtesy Medical Staff for failure to meet the patient care requirements set forth in the Medical Staff Bylaws; (ii) a change from Active Medical Staff to Courtesy Staff for failure to meet the meeting attendance requirements set forth in the Medical Staff Bylaws; or (iii) any other change in category resulting from a failure to meet the minimum objective criteria for a particular Medical Staff Category.

(vii) Denial of requested clinical privileges or requested change in clinical privileges, except where (i) the Applicant or Medical Staff Appointee is requesting clinical privileges in a department in which the number of Medical Staff Appointees has been limited by Section 1 above, or (ii) the Applicant or Medical Staff Appointee fails to meet the minimum objective criteria for the requested privileges.

(viii) Reduction in, restriction of, or failure to renew clinical privileges, other than (i) a temporary restriction in accordance with the Appointment and Corrective Action Procedures; or (ii) where the Medical Staff Appointee no longer meets the minimum objective criteria for such privileges.

(ix) Any other action or recommendation "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act of 1986) any applicant or medical staff appointee.

Section 2.3 -- Actions Not Giving Rise to Hearing Right. A professional review body shall not be deemed to have made a proposal for an adverse recommendation or action,
or to have made such a recommendation or to have taken such an action, and a hearing right under this Section shall not have arisen in any of the following circumstances:

(i) The appointment of an ad hoc investigation committee;
(ii) The conduct of an investigation into any matter;
(iii) The restriction or suspension of a medical staff appointee's clinical privileges for a period of no longer than fourteen (14) days while an investigation is pending;
(iv) The formulation and presentation of any preliminary report of any ad hoc investigation committee to a Credentials Committee or to an officer of the Executive Committee;
(v) The making of a request or issuance of a directive to an applicant or medical staff appointee to appear at an interview or conference before a Credentials Committee, any ad hoc investigation committee, the President/Chief Executive Officer, the Board of Directors or any other professional review body in connection with any investigation prior to a proposed adverse recommendation or action;
(vi) The denial of or refusal to accept an application for initial appointment or reappointment to the medical staff where the application is incomplete; (ii) where the application reflects that the applicant does not meet the minimum objective requirements for appointment or reappointment; or (iii) where the applicant is requesting clinical privileges in a department, subspecialty or service in which the number of medical staff appointees has been limited in accordance with the Medical Staff Bylaws;
(vii) The denial or revocation of temporary privileges in accordance with the Appointment and Corrective Action Procedures;
(viii) The appointment of a newly-appointed medical staff appointee to the provisional staff;
(ix) Automatic termination as provided by the Appointment and Corrective Action Procedures;
(x) The imposition of supervision or observation on a medical staff appointee which supervision or observation does not restrict the clinical privileges of the medical staff appointee or the delivery of professional services to patients;
(xi) The issuance of a letter of warning, admonition or reprimand;
(xii) Corrective counseling;
(xiii) A recommendation that the medical staff appointee be directed to obtain retraining, additional training, or continuing education;
(xiv) The denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Medical Staff Bylaws;
(xv) Any change in medical staff category resulting from the failure of a Medical Staff Appointee to meet the minimum objective criteria for a specific category; or
(xvi) Any recommendation or action not “adversely affecting” (as such term is defined in Section 431(1) of the Act) any applicant or medical staff appointee, or which is not based upon a subjective determination of the professional competency or conduct of the applicant or medical staff appointee.

Section 3. Notice of Adverse Professional Review Recommendation or Action

In the event that a recommendation is made or action taken entitling a Practitioner to a hearing under these Bylaws, the President/CEO or his/her designee in the absence of the President/CEO shall give such Practitioner written notice of such recommendation or action within thirty (30) days of the recommendation and/or action for which hearing is available. Such notice may be given by personal delivery or mailed certified mail, return receipt requested. The Executive Committee or the Board of Directors, as the case may be, shall assist the President/CEO in the preparation of such notice, which shall set forth the adverse professional review recommendation or the proposed adverse professional review action, and a description of the Practitioners action or deficiencies which are complained of, with reference to particular cases involved and any relevant supporting documents, and should be sufficiently detailed to apprise the Practitioner of the charges against him/her, a statement that the Practitioner has a right to request a hearing on the adverse professional review recommendation or the adverse professional review action, that such a hearing
must be requested within thirty (30) days of the Practitioner’s receipt of the notice, and a summary of the Practitioner’s hearing rights.

Section 4. Request for Hearing
If the Practitioner desires a hearing in regard to the adverse professional review recommendation or action, and is entitled to a hearing under these Bylaws, the Practitioner must submit to the President/CEO within thirty (30) days after his/her receipt of the notice referred to in Section 3, a written request for a hearing. Failure of the Practitioner to so request a hearing within said thirty-day period shall constitute a waiver of the Practitioner’s right to a hearing and the adverse professional review recommendation of the Executive Committee shall be acted upon by the Board of Directors, which action shall be final, or the adverse professional review action of the Board of Directors taken without recommendation or contrary to recommendation of the Executive Committee, as the case may be, shall become final and the Practitioner shall have no further right to object or complain about such action.

Section 5. Selection of Hearing Committee
If a Practitioner shall request a hearing and shall otherwise be entitled to a hearing hereunder, an Ad Hoc Hearing Committee shall be promptly appointed for the purpose of conducting the requested hearing. Each Ad Hoc Hearing Committee shall be appointed by the President/CEO. The Ad Hoc Hearing Committee shall consist of three members of the active Medical Staff who are not in direct economic competition with the Practitioner and may reasonably be expected to be familiar with standards of care and conduct in the Practitioner’s specialty or provide similar health care services or treatment. The President/CEO shall designate one of the three members of the Ad Hoc Hearing Committee to serve as chairman of the committee. No person shall be appointed to an Ad Hoc Hearing Committee if such person has taken part in a prior consideration of the matter involved or is personally involved as a participant or witness in the matters to be heard by the Ad Hoc Hearing Committee.

Section 6. Time, Place and Notice of Hearing
The Chairman of the Ad Hoc Hearing Committee shall schedule the time, date and place of the hearing whenever practicable, the hearing shall take place within ninety (90) days of the hearing request. The President/CEO shall send the Practitioner a notice of the time, date and place so scheduled. The hearing date shall be not less than thirty (30) days or more than sixty (60) days after the date of the notice of the hearing. The notice shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Executive Committee or the Board of Directors depending on whose action prompted the request for the hearing. The foregoing notwithstanding, a hearing for the Practitioner who is under a precautionary suspension, temporary suspension or other summary action which is then in effect may be held sooner than thirty (30) days from the date of the hearing notice if both the Executive Committee or the Board of Directors as the case may be and the Practitioner agree that they can adequately prepare for such hearing in the reduced time period.

Section 7. Rights of Participants
During a hearing, the representatives of each of the participants shall have the right to:

a. Call and examine witnesses who voluntarily agree to appear on behalf of the participant calling such witnesses. Notice is hereby given to the participants that neither the Medical Staff, Executive Committee, the Board of Directors, nor MCGHI AUMC has the legal power of subpoena.

b. Introduce exhibits and documents relevant to the issues.
c. Cross-examine any witnesses on any matter relevant to the issues.

d. Rebut any evidence.

e. Subject to the provisions of Section 10 hereof, request that the record of the hearing be made by use of a court reporter or, if the material is to be reduced to writing promptly after the hearing, an electronic recording unit.

If the Practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

Section 8. Representation
The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the Practitioner’s choice. If the Practitioner desires to be represented by an attorney or other person at the hearing, his/her request for a hearing must so state, and identify the person who will represent him/her. The Executive Committee or the Board of Directors, when its action has prompted the hearing, shall appoint a Medical Staff member or a Board of Directors member or an attorney to represent its position at the hearing, to present facts in support of its adverse professional review recommendation or action, and to examine witnesses. Counsel to Executive Committee or Board of Directors and counsel to the Practitioner shall have the right, upon request of his/her client, to be present as an observer at any hearing, even though such counsel’s client has elected not to be represented by counsel at the hearing.

Section 9. Presiding Officer
The chairman of the Ad Hoc Hearing Committee shall be the presiding officer. The chairman shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of proceedings during the hearing, to promulgate rules of procedure not inconsistent with these Bylaws, to exclude or remove any person who is disruptive to an orderly and professional hearing, and to rule on the admission of relevant evidence. Service as chairman shall not in any way prevent the chairman from full participation in the deliberations and actions of the Ad Hoc Hearing Committee. If requested by the Ad Hoc Hearing Committee, the President/CEO may appoint a parliamentarian to serve as an advisor to the chairman of the Ad Hoc Hearing Committee on procedural matters during the course of the hearing and in preparing the committees report. The parliamentarian may, if requested by the chairman, be present during deliberations by the Ad Hoc Hearing Committee, but shall not have a vote on matters to be determined by the Ad Hoc Hearing Committee.

Section 10. Record of Hearing
A record of the hearing shall be kept that is of sufficient accuracy to permit the making of an informed and valid judgment by anybody that may later be called upon to review the record and render a recommendation or decision in the matter. The chairman of the Ad Hoc Hearing Committee shall select the method to be used, such as court reporter, electronic recording unit, detailed transcription or minutes of the proceedings for making the record, subject to the rights of the Practitioner under Section 7 hereof. A Practitioner electing the method under Section 7(e) of this Article shall bear the cost of copies of the record for use by the Practitioner.

Section 11. Obligations to Present Evidence
The Executive Committee, if its adverse professional review recommendation is being questioned, or the Board of Directors, if its adverse professional review action is being questioned, shall have the initial obligation to present evidence showing that the adverse professional review recommendation or action was supported by substantial credible evidence and was not arbitrary or
capricious; and the Practitioner shall thereafter be responsible for presenting evidence in support of his/her challenge to the adverse professional review recommendation or action. Following the close of the Practitioner’s evidence, the Executive Committee or Board of Directors, as the case may be, shall have the right to introduce evidence in rebuttal of that presented by the Practitioner. The Ad Hoc Hearing Committee shall base its decision only on the evidence introduced at the hearing. It shall be the function of the Ad Hoc Hearing Committee to determine whether the adverse professional review recommendation or action being questioned is supported by substantial credible evidence and is neither arbitrary nor capricious. It is not the function of the Ad Hoc Hearing Committee to make a new and distinct determination as to the same subject matter as the adverse professional review recommendation or action, but rather to determine if the Executive Committee or Board of Directors, as the case may be, acted properly in making such adverse professional review recommendation or action by basing it on substantial credible evidence and not being arbitrary or capricious.

Section 12. Evidence Permitted
A hearing need not be conducted according to rules of evidence, which are followed in a court of law. The chairman of the Ad Hoc Hearing Committee may permit the admission of any relevant evidence, which, at his/her discretion, is of the type on which responsible people customarily rely in the conduct of serious affairs.

Section 13. Ad Hoc Hearing Committee Report
Within thirty (30) days after the closing of the hearing, the Ad Hoc Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same together with the hearing record and all other documentation considered by it to the body whose adverse professional review recommendation or action occasioned the hearing. A copy of the Ad Hoc Hearing Committee report shall at the same time be sent to the Practitioner involved. The Ad Hoc Hearing Committee report shall concisely state the reasons for the findings and recommendations made in the report and how such findings and recommendations are supported by the facts as presented at the hearing. The Ad Hoc Hearing Committee report shall specifically recommend that the adverse professional review recommendation or adverse professional review action which was reviewed be followed, be rejected or be modified by the Board of Directors. The Ad Hoc Hearing Committee may request the parties to submit proposed findings and recommendations. No party shall be required to submit proposed findings and recommendations. Proposed findings and recommendations must be submitted to the Ad Hoc Hearing Committee within fourteen (14) days after the closing of the hearing. Any written statement submitted by either party after that date shall not be considered by the Ad Hoc Hearing Committee.

Section 14. Request for Appeal
If the Practitioner, the Executive Committee or the Board of Directors, as the case may be, desires to appeal the findings and recommendations of the Ad Hoc Hearing Committee, such party must file a written request for such an appeal with the President/CEO within thirty (30) days after receipt of a copy of the Ad Hoc Hearing Committees report. Failure to file a timely request for appeal shall constitute waiver by the party of his/her/its right to a review of the report of the Ad Hoc Hearing Committee.

Section 15. Appointment of Ad Hoc Appeals Committee
Within ten (10) days after the receipt by the President/CEO of the request for appeal, the chairman of the Board of Directors shall appoint an Ad Hoc Appeals Committee consisting of five (5) members of the Board of Directors, provided that no such member shall be in direct economic competition with the Practitioner involved and may be reasonably expected to be familiar with the standards of care and conduct in the practitioner’s specialty or provide similar services or treatment, and shall designate one (1) of the appointees as chairman of the committee. The chairman of the Ad Hoc Appeals Committee shall promptly set a date and a time for the consideration of the appeal and
the parties shall be notified in writing thereof. The date of consideration shall be set as soon as practicable, but not less than thirty (30) days after the date of the notice of the appeal hearing.

Section 16. Written Statements
The party seeking the appeal shall submit a written statement detailing the findings, conclusions, recommendations and procedural matters with which he/she or it disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in the preparation thereof. The statement shall be submitted to the Ad Hoc Appeals Committee through the President/CEO at least ten (10) days prior to the scheduled date for the appellate review, with a copy being furnished to the other party. A similar written statement in reply may be submitted by the other party at least two (2) days prior to the scheduled date of the appellate review, with a copy being furnished to the other party. Failure of the party requesting an appeal to file such written statement in a timely manner shall constitute a waiver of the right to appellate review.

Section 17. Oral Argument
If the party requesting an appeal desires to have oral arguments before the Ad Hoc Appeals Committee, he or it shall so request in the request for appeal. If the other party desires oral arguments before the Ad Hoc Appeals Committee, he or it shall file a request with the President/CEO within five (5) days after the filing of the request for appeal. No party shall have a right to oral argument and the decision as to whether or not to permit oral arguments shall be entirely within the discretion of the ad hoc appeals committee. Oral arguments may be required by the Ad Hoc Appeals Committee even if not requested by either party. If oral arguments are made, they may be presented by one (1) representative of each party.

Section 18. Consideration of New or Additional Matters
New or additional matters or evidence not raised or presented during the original hearing before the Ad Hoc Hearing Committee or in the Ad Hoc Hearing Committee report, or otherwise reflected in the record, shall be introduced during the appellate review process only under unusual circumstances. The ad hoc appeals committee, at its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

Section 19. Function of Ad Hoc Appeals Committee
The function of the ad hoc appeals committee shall be to determine whether or not the hearing procedures set forth in these Bylaws have been complied with and whether the Ad Hoc Hearing Committee has properly carried out its functions in accordance with these Bylaws and has made a proper determination as to whether or not the adverse professional review recommendation or action was supported by substantial credible evidence and was not arbitrary and capricious.

Section 20. Report of Ad Hoc Appeals Committee
The ad hoc appeals committee shall, within (30) days after its consideration of the appeal, prepare a written report of its findings and recommendations in regard to the matters before it. The report may recommend affirmation, reversal or modification of the findings and recommendations of the Ad Hoc Hearing Committee before it or may refer the matter back to the Ad Hoc Hearing Committee with directions for further consideration or additional hearings. The report shall be furnished promptly to the chairman of the Board of Directors with a copy to the Practitioner.

Section 21. Action by Board of Directors
Once the hearing and appeal process has been completed, or the parties involved have waived their rights to any further hearing or appeal hereunder, the Board of Directors may then act upon the recommendations made to it by the Executive Committee or may reaffirm its own action from which an appeal was taken, as the case may be, and such action by the Board of Directors shall
be final and subject to no further appeal. Notice of the final action of the Board of Directors, which shall include a statement of the basis of the decision, shall promptly be given to the Practitioner and the Executive Committee. The President/CEO shall promptly report to the Georgia Composite Medical Board or other appropriate authorities, as required by state and/or federal law, any final adverse professional review action.

ARTICLE VII - CATEGORIES OF THE MEDICAL STAFF

Section 1. Categories of the Medical Staff

The Medical Staff shall be organized with the following categories for the members of the Medical Staff:

A. Provisional Medical Staff
B. Active Medical Staff
C. Consulting Medical Staff
D. Courtesy Medical Staff
E. Honorary Medical Staff
F. Military Medical Staff
G. Administrative Medical Staff

Section 2. The Provisional Staff

All new appointments to the medical staff shall be Provisional for the first year. At the end of the Provisional period, the Clinical Service Chief shall make recommendations to the Credentials Committee regarding the appointment to the Medical Staff.

Section 3. The Active Medical Staff

Subsection 1. The Active Medical Staff shall include those physicians and dentists who regularly provide care to patients in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia, who are able to provide and who will ensure continuous care to their patients and who assume all the functions and responsibilities of membership on the Active Medical Staff including, where appropriate, emergency services care and consultation assignments at the discretion of the Clinical Service Chief and with the approval of the CEO/CMO. Each such physician or dentist shall provide care at Georgia Regents AU Medical Center or the Children’s Hospital of Georgia and its affiliated off-site clinical care facilities to a sufficient number of inpatients and/or outpatients each year to provide adequate activity to evaluate quality of care in the area of practice, and shall be subject to Ongoing Professional Practice Evaluation (OPPE). At the time of reappointment, members of the Active Medical Staff shall include documentation of their clinical activity during the previous two years to justify their retention as members of the Active Medical Staff. If their activity is not sufficient for evaluation, they may request exemption from this requirement by requesting a waiver from the requirement based on their practice and their involvement with Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia. Such waiver must be recommended by the Clinical Service Chief, the Credentials Committee and the Medical Executive Committee.

Subsection 2. Active Medical Staff members shall be permitted to vote on all matters which are brought before the Medical Staff including, but not limited to, amendments to these Bylaws, may be appointed to and are encouraged to serve on Medical Staff, Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia’s committees, and may hold office a committee. The Active Medical Staff members alone shall constitute the voting membership of the Medical Staff.

Subsection 3. The privilege of any member of the Active Medical Staff to admit patients to Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia on an inpatient or outpatient basis shall be as set forth in the delineated Clinical Privileges granted to such member.
Section 4. The Consulting Medical Staff

Subsection 1. The Consulting Medical Staff shall include physicians and dentists who do not ordinarily practice at Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia, but because of their specialized medical ability will be called on as consultants to enhance the total care of the patients.

Subsection 2. Within the scope of their individual Clinical Privileges, the members of the Consulting Medical Staff are to provide their services in the care of patients as requested by members of the Medical Staff. They shall not be granted admitting privileges.

Subsection 3. The Consulting Medical Staff members are not required to attend Medical Staff meetings and are not eligible to vote or hold an elected position on the Medical Staff. The Consulting Medical Staff members can, unless otherwise provided herein, serve on committees and vote on committee business. The Consulting Medical Staff members are subject to Ongoing Professional Practice Evaluation (OPPE), which shall at a minimum include a bi-annual review of the following:

- Number of validated reports for unprofessional behavior;
- Compliance with medical records obligations; and
- Departmental peer review (may require 100% review of care for low volume (<10 records).

Section 5. The Courtesy Medical Staff

The Courtesy Medical Staff shall include those physicians and dentists who are qualified for Active Medical Staff membership except that they provide care to fewer than twelve (12) inpatients and/or outpatients each year. Courtesy Medical Staff members are not expected to admit patients to the hospital, and their privileges are primarily intended to provide them access to the charts for teaching purposes or following up upon their own patients. Courtesy Medical Staff members are encouraged, but not required, to attend Medical Staff meetings. Courtesy Medical Staff members are not eligible to vote or hold an elected position on the Medical Staff. Courtesy Medical Staff members can, unless otherwise provided herein, serve on Medical Staff committees and vote on committee business. Courtesy Medical Staff members who provide care to twelve or more inpatients and/or outpatients in a year must apply for and obtain appointment to the Active Medical Staff.

Section 6. The Honorary Medical Staff

The Honorary Medical Staff shall consist of those former members of the Medical Staff who, by their long and meritorious service to the Hospital, warrant such recognition and are distinguished professionals of outstanding reputation in medicine. An Honorary Medical Staff member is not eligible to vote or hold elected position on the Medical Staff, is not required to attend meetings, does not provide care to patients, shall not have Clinical Privileges and shall not have assigned duties. Appointment to the Honorary Medical Staff does not require biennial appointment or review, but can be reviewed at the discretion of the Medical Director. Candidates for Honorary Staff must be nominated by an active medical staff member, endorsed by the Clinical Service Chief and recommended for approval by the Credentials Committee before being forwarded for approval to the Medical Executive Committee and Board of Directors. The Board of Directors will approve only those candidates who are, in the opinion of the Board, of such professional eminence as to merit this honor.

Section 7. The Military Medical Staff

Subsection 1. The Military Medical Staff shall be active duty military physicians and dentists with clinical care assignments to Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia.
Subsection 2. The Military Medical Staff members are not required to attend Medical Staff meetings and are not eligible to vote or to hold an elected position on the Medical Staff. The Military Medical Staff members can, unless otherwise provided herein, serve on Medical Staff committees and vote on committee business.

Subsection 3. A Military Medical Staff member’s Clinical Privileges and Medical Staff membership shall automatically terminate upon the termination of such individuals clinical care assignment in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia. The deadline for applications for reappointment will be waived in cases of military deployment as delineated in the Medical Staff Credentialing Policy.

Section 8. The Administrative Medical Staff
The Administrative Medical Staff shall consist of members of the Medical Staff who meet the qualifications for membership on the Medical Staff under Article IV of these Bylaws and demonstrate qualifications for clinical privileges under Article V. The Administrative Medical Staff is limited to physicians appointed to serve in leadership positions requiring membership on the Medical Staff, such as the Chief Medical Officer. Those appointed to the Administrative Medical Staff shall have the same voting privileges as those on the Active Staff, as set forth in Section 3, Subsection 2 of this Article.

Section 9. Practitioners who are not Members of the Medical Staff
There are Practitioners who have Clinical Privileges but are not members of the Medical Staff such as psychologists, optometrists, and podiatrists. These individuals may attend Medical Staff meetings upon invitation and may serve on Medical Staff committees, but without vote. Practitioners and other assistants shall be subject to credentialing/privileging and regulations in accordance with the Rules and Regulations.

ARTICLE VIII - CLINICAL SERVICES

Section 1. Organization
The Medical Staff shall be organized into the following clinical services: Anesthesiology, Emergency Medicine, Family Medicine, Hospitalist, Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pathology and Laboratory Medicine, Pediatrics, Psychiatry, Radiology, Radiation Oncology and Surgery.

Section 2. Service Chiefs
Only those members of the Medical Staff who are board certified or who can demonstrate comparable competence, through the Credentialing process and who are Faculty Members are eligible to serve as Service Chiefs. It is preferable but not required that the Service Chief be the Chair of the corresponding GRU-Augusta University Clinical Department. The Service Chiefs will carry out their duties and responsibilities in accordance with these Bylaws and the Rules and Regulations. The Service Chief is responsible for:

a. being accountable for all clinical and administrative activities within each clinical service unless otherwise provided for by Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia.

b. continuing surveillance of clinical competence, professional performance, and health issues (affecting ability to provide care) of individuals who have delineated Clinical Privileges in each
clinical service and reporting any concerns to the Credentials Committee within 30 days.
c. recommending to the Executive Committee the criteria for Clinical Privileges that are relevant to the
care provided in the clinical service.
d. recommending Clinical Privileges for each member assigned to the clinical service;
e. the continuous assessment and improvement of the quality of care, treatment, and services
f. assessing and recommending off site sources for needed patient care, treatment and services
not offered by Georgia Regents Medical Center and/or the Children’s Hospital of Georgia:
g. the integration of the clinical service into the primary functions of the organization;
h. the coordination and integration of interdepartmental and intradepartmental services;
i. the development and implementation of policies and procedures that guide and support the
provision of care, treatment and services;
j. the recommendation for a sufficient number of qualified and competent persons to provide care,
treatment, and service;
k. the determination of the qualifications and competence of service personnel who are not
practitioners and who provide patient care, treatment and services;
l. the maintenance of quality control programs, as appropriate;
m. the orientation and continuing education of all persons in the service;
n. recommendations for space and other resources needed by the service
o. reporting physicians on any extended leave of absence (30 days or greater) with an anticipated
return date to the Credentials Committee.
p. defines the components of the services clinical practice log which are to be submitted by new
applicants for membership and by current medical staff for renewal of privileges. Notify of and
reinforce to providers the need to maintain these logs for privileges.
q. additional duties as outlined in their MCGH/AUMC job descriptions.

Whenever a vacancy exists for the position of Service Chief, after consultation with GRMA/AUMA,
the AUMC GRMA Chief Medical Officer, and the Dean of the Medical College of Georgia, the Chief
Executive Officer of GRMC/AUMC shall recommend to the Board of Directors candidate for
appointment as Service Chief (s).

At GRU-Augusta University/MCGH/AUMC/GRMA/AUMA–administered off-site clinical care facilities,
the responsibilities of the Clinical Service Chief will be delegated to the supervising physician for
those practitioners providing care at off-site facilities who have no patient care responsibilities at
the primary MCGH/AUMC site but are privileged by the Medical Staff of MCGH/AUMC, Credentials
Committees, The Clinical Service Chiefs for these outlying clinical facilities will be selected, after
consultation with GRMA/AUMA, by the Chief Medical Officer of MCGH/AUMC, President of the
Medical Staff and Chairman of the Credentials Committee.

Section 3. Assignment to Clinical Services

Assignment of Practitioners granted Clinical Privileges to a clinical service or services shall be
made at the time of appointment and/or Privileging on the recommendation of the Chief Medical
Officer, and the Executive Committee subject to the approval by the Board of Directors. Each
Practitioner shall be responsible to the Service Chief of the clinical service to which the person is
assigned.
ARTICLE IX - OFFICERS AND COMMITTEES

Section 1. Officers of the Medical Staff
The Officers of the Medical Staff shall be appointed or elected, as provided for herein, to support the organization’s goals for excellence through continuous performance improvement. Their duties shall be divided based on the needs of patients and their caregivers. The officers of the Medical Staff shall be the Chief Medical Officer; the President; the President-Elect; the Service Chiefs; the Chairs of the Medical Staff Committees; and the members of the Executive Committee.

Section 2. Qualifications of Officers
Each officer shall be a member of the Active Medical Staff in good standing at the time of nomination and selection and must remain in good standing during his/her term in office, except that this requirement shall not apply to the Chief Medical Officer, but he/she must be a member in good standing of the Active Medical Staff.

Section 3. Nomination and Election of Elected Officers
Each year, the President of the Medical Staff shall appoint a Nominating Committee which shall be composed of the President-Elect, Chief Medical Officer, the immediate past President and two members at large chosen by the President from the members of the Active Medical Staff. The nominating committee’s functions shall be to nominate candidates for the positions of President-Elect and two at-large memberships on the Executive Committee for the election to be held at the next Annual Meeting. This ballot will be presented at the Annual Meeting. Additional nominations may be made from the floor at the meeting and added to the ballot by write-in. The elected officers shall be the nominees receiving the largest number of votes from those cast for the respective office for which he/she was a nominee. The results of the vote will be tabulated and announced prior to the conclusion of the Annual Meeting of the Division. If vacancies occur in any of the elected positions, the same procedures shall be followed to fill the vacancy except that the meeting at which the election shall occur need not be the Annual Meeting, but may be a special meeting, or the President and Chief Medical Officer may make a recommendation to the Executive Committee to appoint a replacement until the next Annual Meeting. Nothing in this section prevents the Medical Staff from holding an election of officers by electronic vote rather than at the Annual Meeting.

Section 4. Terms of Office
Unless earlier removed as herein provided, the President and President-Elect (who also shall serve as the Chair of the Credentials Committee) shall hold office for a one-year term. Appointed officers of the Medical Staff shall hold office until their successors are duly appointed or elected and have qualified for office, with the exception of those who resign or are removed from office according to these By-Laws. Subject to Article IX, Section 6, Subsection 2, the President of the Medical Staff whose term begins in odd years will be from the Pediatric service, and the President of the Medical Staff whose term begins in even years will be from the Adult service.

Section 5. Removal from Office
Officers may be removed from office by the Board of Directors for one or more of the following reasons: unsatisfactory performance of assigned medical administrative duties, violation of professional ethics or other behavior detrimental to the reputation of MCG AU, Medical Center and/or the Children’s Hospital of Georgia; involuntary loss of Medical Staff membership or Clinical Privileges; illness; and/or unwillingness to serve as determined by a simple majority of the applicable Executive Committee and approved by the Board of Directors. Removal from office may not affect the former officer’s Medical Staff membership and Clinical Privileges.

Section 6. Medical Staff Officers and their Duties
Subsection 1. The Chief Medical Officer. The Chief Medical Officer of MCGH/AUMC is appointed by the President/CEO and approved by the Board of Directors. The Chief Medical Officer is responsible for coordinating all clinical activities for MCGH/AUMC and for working with Medical Staff Officers, clinical services, programs and service lines to ensure the appropriateness of care and to improve the quality of care within the bounds of appropriate utilization of resources. The Chief Medical Officer is a member of all standing and special committees of the Medical Staff ex officio with vote provided that he/she meets the requirements of Section 2 of this Article. The Chief Medical Officer works with the officers of the Medical Staff and the President/CEO, the Vice President of Patient Care Services/Chief Nursing Officer, and the Board of Directors to ensure that all matters pertaining to the quality and appropriateness of patient care are discussed and resolved in ways which support continuous performance improvement.

Subsection 2. Medical Staff President and President-Elect. The President-Elect shall, upon completing the term for such position, automatically become the President. The President shall call and preside at the Annual Meeting and all general or special meetings of the Medical Staff. The President shall:

1. Act in coordination and cooperation with the Chief Medical Officer, the Vice President of Patient Care Services/Chief Nursing Officer and the President/CEO and his/her designees in all matters of mutual concern within Georgia RegentsAU Medical Center;
2. Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;
3. Serve as Chairman of the Medical Staff Executive Committee;
4. Serve as an ex officio member with vote on all standing and special Medical Staff committees;
5. In conjunction with the Chief Medical Officer Georgia RegentsAU Medical Center and/or the Children’s Hospital of Georgia, or Co-Medical Director of the Children’s Hospital of Georgia he/she shall be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff’s compliance with the procedural requirements in all instances where corrective action has been requested;
6. Recommend, with the Chief Medical Officer, members to be considered for appointment to all Medical Staff Committees, except the Executive Committees and those committees specifically so designated in these Bylaws and the Rules and Regulations;
7. Act in conjunction with the Chief Medical Officer and the President/CEO as a Medical Staff liaison to the Board of Directors.
8. Transition after consolidation – It is the intention of the Medical Staff through these Bylaws to alternate the presidency of the Medical Staff between a pediatric and adult practitioner, and to allow those Members elected as officers immediately before the consolidation of the adult and pediatric divisions of the Medical Staffs in 2015 to serve as elected. The President of the Medical Staff whose term begins in odd years will be from the Pediatric service. The President of the Medical Staff whose term begins in even years will be from the Adult service. See Article IX, Section 4.

In that regard, beginning with the term commencing on July 1, 2015, the current President-Elect of the former pediatric division of the Medical Staff will become President of the Medical Staff. On July 1, 2015, the current Chair of the Credentials Committee will become the President-Elect, and then will become President on July 1, 2016.

On July 1, 2016, the current President-Elect of the former pediatric division of the
Medical Staff will become the President-Elect and Chair of the Credentials Committee, and then become the President of the Medical Staff on July 1, 2017. On July 1, 2017, the current President-Elect of the Medical Staff will become the Chair of the Credentials Committee, and then become the President of the Medical Staff on July 1, 2018. An election under these Bylaws will take place to determine the pediatric practitioner who will become the President-Elect and Chair of the Credentials Committee as of July 1, 2018.

Subsection 4. The Medical Directors

For the Adult Division of the Georgia Regents Medical Center there may be a Medical Director. The Medical Director shall be a member of the faculty and appointed by the Board of Directors following its receipt of a recommendation from the President/CEO, Chief Medical Officer, and the Executive Committee.

For the Pediatric Division of the Children’s Hospital of Georgia there shall be a Pediatrician-in-Chief and a Surgeon-in-Chief who shall serve as Co-Medical Directors. Each of these physicians shall be faculty members and appointed by the Board of Directors following its receipt of recommendations from the President/CEO, the Chief Medical Officer and the Medical Executive Committee. The following Medicine clinical services, including pediatricians, pediatric and adolescent medical subspecialties, family physicians, emergency medicine specialists, clinical pathologists, neonatologists and psychiatrists who serve children and adolescents shall report to the Pediatrician-in-Chief, Co-Medical Director. The following Surgery clinical services including pediatric and adolescent general and subspecialty surgeons, anesthesiologists, anatomic pathologists, dentists and oral surgeons shall report to the Surgeon-in-Chief, Co-Medical Director.

Responsibilities of the Medical Director and Co-Medical Directors may include both clinical and administrative duties.

1. Be responsible to the President/CEO and the Chief Medical Officer for the medical direction of all approved Children’s Hospital of Georgia and MCGHI AUMC pediatric and newborn patient care programs;
2. Work with the President of the Medical Staff and the Chief Medical Officer, to maintain a positive working relationship between the Medical Staff and MCGHI AUMC administration;
3. In conjunction with the President of the Medical Staff, present information regarding the Bylaws, Rules and Regulations, and views, needs and grievances of the Medical Staff to MCGHI AUMC administration and to the Board of Directors;
4. In conjunction with the President of the Medical Staff, report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff’s responsibility to provide patient care, teaching and research;
5. Serve as an ex-officio member with vote on all Medical Staff Committees;
6. Serve as a member of the Board of Directors’ Joint Conference Committee;
7. Work with the Vice President of Patient Care Services/ Chief Nursing Officer or his/her designee on all matters relating to the quality and appropriateness of patient care and to continuously improve the services available to Children’s Hospital of Georgia patients; and
8. Recommend, with the President of the Medical Staff, members to be considered for appointment to all Medical Staff Committees, except the Executive Committee and such other positions designated in these Bylaws or the Rules and Regulations.

Subsection 5. Associate Medical Directors. Associate Medical Directors may be appointed by
the Board of Directors to assist with specific Medical Staff responsibilities as designated by the Board of Directors. The President/CEO, the Chief Medical Officer, Georgia Regents Medical Center and/or the Children’s Hospital of Georgia and/or the appropriate Executive Committee may recommend such appointments to the Board of Directors. The Associate Medical Directors may assist the Medical Director, Georgia Regents Medical Center or Co-Medical Directors of the Children’s Hospital of Georgia as appropriate.

Subsection 6. Service Chiefs. Service Chiefs shall be appointed and fulfill the responsibilities as set out in Article VIII, Section 2.

Subsection 7. Medical Staff Committee Chairmen. The Chairmen of the Medical Staff Committees shall be considered Officers of the Medical Staff and shall have duties and responsibilities as described in these Medical Staff Bylaws, Rules and Regulations.

Subsection 8. Unit, Program, and Service Line Medical Directors. The President/CEO may recommend to the Board of Directors appointment of unit, program and service line Medical Directors. Each recommendation will be accompanied by a specific job description and a proposed candidate for approval or rejection. Appointed unit, program and service line Medical Directors shall be considered Officers of the Medical Staff and shall be responsible for the performance of their assigned job responsibilities. They shall work cooperatively with the other Officers of the Medical Staff and the President/CEO, Chief Nursing Officer, or their assigned administrative counterparts.

Subsection 9. Members of the Executive Committee. The Members of the Executive Committee shall be considered Officers of the Medical Staff and shall have duties and responsibilities as described in these Bylaws and the Rules and Regulations.

Section 7. Committees

There shall be four permanent standing committees of the Medical Staff are: the Executive Committee, the Credentials Committee, the Performance Improvement Committee, and the Bylaws Committee. Additional Standing Committees may be appointed by the Medical Executive Committee as needed. Special committees may be created from time to time by the President of the Medical Staff and by the Board of Directors. Except as herein otherwise provided, all members of standing committees shall be appointed by the Executive Committee on recommendation by the President of the Medical Staff after consultation with the Chief Medical Officer. All members of the Medical Staff and all residents are eligible to serve on committees as provided for in these Bylaws and the Rules and Regulations. Anything in these Bylaws or the Rules and Regulations notwithstanding, only members of the Active Medical Staff are eligible to serve on the Executive Committee. Appointments to the standing committees are made annually and are from July 1 through June 30. Appointed members of standing committees serve until removed or replaced and may serve on more than one committee, and may be reappointed for additional service.

Section 8. Executive Committee

Subsection 1. Membership. The voting members of the Medical Executive Committee shall consist of the following:

1. President of the Medical Staff
2. President-Elect of the Medical Staff (who also serves as the Chair of the Credentials Committee)
3. Immediate Past President of the Medical Staff
4. Pediatric Surgeon-in-Chief
5. Pediatrician-in-Chief
6. Chair, Department of Medicine
7. Chair, Department of Surgery
8. Chair, Department of Emergency Medicine
9. Chair, Department of Psychiatry
10. At-Large, Adult
11. At-Large, Adult
12. At-Large, Pediatrics
13. At-Large, Pediatrics
14. One Member rotating between Anesthesia, Radiology, and Pathology. The rotating Members will rotate in the following order: Anesthesia, Radiology, and Pathology.
15. Three Members rotating between Neurosciences, Family Medicine, ENT, Orthopedics, OB-GYN, and Ophthalmology. For terms beginning in odd years, the rotating members will be from Neurosciences, Family Medicine, and ENT. For terms beginning in even years, the rotating members will be from Orthopedics, OB-GYN, and Ophthalmology.

The following will be non-voting members of the Medical Executive Committee: Clinical Service Chiefs, Chief Medical Officer, Chief Nursing Officer, Chief Executive Officer, Chief Operating Officer, and the Designated Institutional Official.

The presence of at least forty percent (40%) of the voting members of the Medical Executive Committee shall constitute a quorum.

The Chairs who are members of the Medical Executive Committee have the discretion to appoint another Member of the Active Medical Staff as their designee on the Medical Executive Committee. Such a designation must be in writing and submitted to the President of the Medical Staff in advance of the designee’s participation on the Medical Executive Committee. The At-Large members shall serve two year terms.

Subsection 2. Duties of the Committee. The Executive Committee shall oversee quality of care, coordinate the activities and general policies of the Clinical Services, and act for the Medical Staff as a whole, subject to the limitations of the Bylaws and Rules and Regulations. It shall receive and act upon reports of the Quality/Safety Operations Committee, the Credentials Committee, Graduate Medical Education Committee, and other committees of the Medical Staff. The Executive Committee is delegated the primary authority over activities related to the functions of self-governance of the Medical Staff and over activities related to the functions of performance improvement of the professional services provided by Practitioners with Clinical Privileges. The Executive Committee is empowered to act for the Medical Staff in the intervals between Medical Staff meetings.

The Executive Committee is responsible for making Medical Staff recommendations directly to the Board of Directors for its consideration. Such recommendations may include but are not limited to the following:

- The Medical Staff structure;
- The mechanism used to review credentials and to delineate individual Clinical Privileges;
- Recommendations of individuals for Medical Staff membership and/or Clinical Privileges;
- Participation of the Medical Staff in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia Performance-Improvement activities;
- Mechanism by which Medical Staff membership may be terminated;
- Coordination of activities and general policies of the various clinical services;
- Hearing and appeals procedures;
- Action on reports and recommendations from Medical Staff committees, clinical services, assigned activity groups and Georgia Regents AU Medical Center and/or Children’s Hospital of Georgia professional policy development activities;
- Recommendation of action to the President/CEO and the Chief Medical Officer or
their designees on medical administrative matters;

- Development and implementation of policies of the Medical Staff not otherwise the responsibility of the clinical services;
- Provision of liaison between the Medical Staff, the Chief Medical Officer, the President/CEO, the President of the Medical Staff, and the Board of Directors; and
- Recommendations on management matters.

**Subsection 3. Meetings.** The Executive Committee shall have regularly scheduled monthly meetings and shall meet at such additional times as it is called to meet by the President of the Medical Staff. A record of its proceedings shall be prepared and kept in the MCGHAUMC Medical Staff Office. Except for actions in executive session, and in accordance with all requirements of law, an abstract of its proceedings may be provided to all members of the Active Medical Staff. The agenda of all meetings shall be printed in the notice of meetings provided in a timely fashion to each member in advance of each meeting. The President of the Medical Staff or his/her designee assisted by the Chief Medical Officer and the MCGHAUMC Medical Staff Office will prepare the agenda. Members of the Executive Committee may submit items for the agenda.

**Subsection 4. Accreditation.** The Executive Committee shall be responsible for reviewing accreditation standards and shall act to bring the Medical Staff practices into compliance with current standards for accreditation by the appropriate agencies.

**Subsection 5. Reports.** In addition to the record of its proceedings, the Executive Committee will prepare and present an annual report to the Medical Staff at its Annual Meeting. It shall prepare such other reports as may be required by the Board of Directors.

**Section 9. Credentials Committee**

**Subsection 1. Membership.** Members of the Credentials Committee shall consist of the President-Elect of the Medical Staff and such members as shall be appointed by the Executive Committee upon recommendation of the President of the Medical Staff. The President-Elect of the Medical Staff shall serve as Chairman of the Credentials Committee. The ex-officio members shall include those Medical Staff officers designated to serve in such position.

**Subsection 2. Duties: Appointment and Reappointments.** The Credentials Committee shall evaluate the credentials of all applicants for membership on the Medical Staff and other applicants for Clinical Privileges who are Practitioners in accordance with the provisions of these Bylaws and the Rules and Regulations. It shall make recommendations thereon to the Executive Committee. It shall review biennially the re-application of each member of the Medical Staff and each Practitioner with Clinical Privileges making its recommendation for reappointment and/or extension of Clinical Privileges to the Executive Committee.

**Subsection 3. Investigation of Professional Skill and Ethical Conduct.** The Credentials Committee shall investigate any reported breach of ethics, alleged medical misconduct, potential failure to meet standard of care and review reports of the Quality/Safety Operations Committee, including direct reports from the Peer Review Subcommittee of the Performance Improvement Committee, referred to it regarding the performance of any Medical Staff member or other Practitioner with Clinical Privileges. It may review clinical records to carry out this direction. Upon investigation and review, it will forward its recommendations to the Executive Committee. These recommendations may include: no breach of ethics or performance; a change in the Clinical Privileges, appointment, and service assignment of the Medical Staff member or other Practitioner with Clinical Privileges; further action by the Executive Committee to limit or suspend the Clinical Privileges of the Medical Staff member or other Practitioner with Clinical Privileges.
Subsection 4. Credentialing Policy. The Credentials Committee shall assist the Chief Medical Officer and Medical Staff Office in developing a Medical Staff Credentialing policy containing all Rules and Regulations used in Credentialing and Privileging.

Section 10. Quality/Safety Operations Committee

Subsection 1. Membership. Members of the Quality/Safety Operations Committee shall be appointed by the Executive Committee upon recommendation of the President of the Medical Staff. The Executive Committee may designate a member of the Quality/Safety Operations Committee as its Chairman. The ex-officio members shall include those Medical Staff officers herein designated to serve in such position.

Subsection 2. Duties. The Quality/Safety Operations Committee will monitor clinical performance, undertake corrective action where indicated and develop mechanisms to improve institutional clinical functions. These duties include, but are not limited to: standards of clinical activity, review of records, utilization of drugs, use of technical and other resources, review of clinical-pathological correlations, epidemiologic monitoring of hospitalization related illness, use of biological materials such as blood and blood products, emergency procedures, staffing, and hospital procedures that affect patient safety and information used as part of the performance improvement mechanisms, measurement, or assessment including Sentinel event data. The Performance Improvement Committee will also establish templates for Morbidity and Mortality Reports and serve as a repository for minutes of Morbidity and Mortality Conferences for all clinical sections. These functions can be evaluated by designation of subcommittees at the discretion of the President of the Medical Staff. All members of the Medical Staff and all residents may be members of subcommittees.

Subsection 3. Subcommittees. Subcommittees shall review functions assigned to them as defined in current manuals and regulations of appropriate accrediting and licensing agencies. They shall meet with a frequency commensurate with their workload but at least quarterly. The Chief Medical Officer may designate staff support for subcommittee functions.

Subsection 4. Meetings and Reports. The Quality/Safety Operations Committee will meet at least eight times per year. Minutes of its meetings will be kept. A report of each meeting with recommendations will be made to the Executive Committee.

Subsection 5. Charges. A charge for specific action, review or investigation may be made to the Quality/Safety Operations Committee or one of its subcommittees by the Executive Committee. Such a direction to the Committee or one of its subcommittees may involve specific functional areas listed in these Bylaws or other areas, which from time to time appear appropriate to the Executive Committee. Such Quality/Safety Operations Committee charges will be reviewed regularly, but at least biennially by the Executive Committee.

Section 11. Bylaws Committee

Each year, the Chief Medical Officer shall appoint a Bylaws committee which shall be composed of the President, President-Elect, and immediate past President of the Medical Staff and two members at large from the members of the Active Medical Staff. The ex-officio members shall include those Medical Staff officers designated to serve in such position. The Bylaws Committee will review these Bylaws and Rules and Regulations at least annually for revisions necessary to improve or enhance or to conform them to current standard practice. The Bylaws Committee will report its recommendations on changes of the Bylaws to the Executive Committee and to the general Medical Staff membership at the Annual Meeting or a special meeting of the Medical Staff. Recommended changes to the Rules and Regulations shall be reported to the Executive Committee.
Section 12. Special Committees
Special committees shall be appointed by the President of the Medical Staff. Wherever possible, and if appropriate, special functions should be assigned to existing functional areas. Committees shall receive a charge defining the duration of their life, which is not to exceed one year; the scope of their duties, the rights they possess to take action, the frequency of their reports, which is to be not less than annually, and the frequency of their meetings. The President of the Medical Staff and the Chief Medical Officer shall be members of all special committees. The President of the Medical Staff may designate a Chairman or regular and/or ex officio may act in that capacity himself/herself. He/she may designate a member of the Medical Staff to represent him in special committee activities. The Executive Committee may direct the President of the Medical Staff to establish a special committee and may provide a charge to it, or to those special committees independently established by the President of the Medical Staff.

Section 13. MCGHI-AUMC Medical Staff Office
The MCGHI-AUMC Medical Staff Office employees shall keep accurate and complete minutes of all meetings, call meetings on order of the President of the Medical Staff, attend to all correspondence and perform such other duties as ordinarily pertain to Medical Staff business.

ARTICLE X - MEETINGS

Section 1. The Annual Meeting
There shall be at least one meeting of the Medical Staff annually, the Annual Meeting, held preferably in the fourth quarter of the Calendar Year. The Fiscal Year is from July 1 to June 30 each year. Each Medical Staff member shall be sent the agenda and notification of the meeting not less than one week in advance of this meeting unless an amendment to these Bylaws is to be considered in which case the notice must be sent at least 15 days before the date set for the meeting. The President of the Medical Staff shall call this meeting. For the fiscal year in which these Bylaws are adopted the meeting at which they are adopted may be the Annual Meeting if the proper notices and nominating procedures have been followed. If not, the Annual Meeting shall be held as soon as reasonably practicable thereafter.

Section 2. Special Meetings
Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, the Chief Medical Officer, the Board of Directors, the Executive Committee, or any five members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of any special meeting shall be given to the members of the Medical Staff at least 48 hours before the time set for the meeting, unless an amendment to these Bylaws is to be considered in which case the notice must be sent at least 15 days before the date set for the meeting.

Section 3. Attendance at Meetings
Subsection 1. Attendance of the Active Medical Staff at the annual or special Medical Staff meetings and at clinical service meetings is expected unless excused by the Service Chief for just cause. Each clinical service will monitor attendance at meetings to determine that a Medical Staff member attends at least one-half of the meetings or is excused with justifiable reason.

Subsection 2. Members of the Consulting Medical Staff, the Courtesy Medical Staff, the Honorary Medical Staff and Military Medical Staff are encouraged, but are not required, to attend Medical Staff meetings.
Section 4. Quorum
Forty members of the Active Medical Staff shall constitute a quorum.

Section 5. Meeting Rules
All Medical Staff meetings and meetings of the committees of the Medical Staff shall be conducted in accordance with rules and procedures established by the chairman conducting the meeting.

ARTICLE XI - RULES, REGULATIONS, POLICIES AND PROCEDURES

Section 1. Establishment of Policies, Procedures, Rules and Regulations of the Medical Staff
The Executive Committee shall adopt from time to time such Rules and Regulations, as it deems appropriate to carry out the business and functions of the Medical Staff and to modify or amend existing Rules and Regulations. Upon the adoption of any new Rule or Regulation or the adoption of an amendment or modification to an existing Rule or Regulation, the same shall be promptly sent to the President/CEO who shall present it to the Board of Directors at its next regularly scheduled meeting or any sooner held special meeting called for the purpose of considering same. If such new Rule or Regulation or such amendment or modification of an existing Rule or Regulation is approved by the Board of Directors, it shall immediately become effective unless it shall state a later effective date, in which event it shall become effective on the date so stated.

The Medical Staff at its next meeting after notice of a new Rule or Regulation or the amendment or modification of an existing Rule or Regulation is given in accordance with Section 2 of this Article may adopt a resolution objecting to or recommending modifications of any new Rule or Regulation or any amendment or modification of an existing Rule or Regulation, which resolution shall be promptly sent to the President/CEO. The President/CEO shall present such resolution to the Board of Directors at its next regularly scheduled meeting or at any sooner held special meeting called for the purpose of considering such resolution. The Board of Directors shall consider the matter and make a determination as to whether to continue the Rule or Regulation in question in effect, to modify or alter same or to revoke it. The determination of the Board of Directors shall be final.

Section 2. Notice of Policies, Procedures, Rules and Regulations
When a Rule or Regulation or a modification or amendment thereof has been approved by the Board of Directors, the MCGH-AUMC Medical Staff office shall promptly send each member of the Medical Staff a copy of the Rule or Regulation or the modification or amendment thereof.

Section 3. Conflict Resolution
Medical Staff members may appear before the Executive Committee to voice a concern over any alterations of the Rules and Regulations or policies and procedures.

ARTICLE XII - PEER REVIEW

Section 1. Review of Professional Practices
One of the main functions of the Medical Staff is to provide for the review of professional practices in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia for the purpose of reducing morbidity and mortality and for the improvement care of the patients. This review shall include, but shall not be limited to:

a. the quality of the care provided to patients as rendered in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia;
b. the review of medical treatment and diagnostic and surgical procedures in order to further safe and adequate treatment of patients in Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia

c. the evaluation of medical and health care services or the qualifications and professional competence of persons performing or seeking to perform services.

These functions shall be carried out by the various clinical services and committees established under these Bylaws and the Rules and Regulations and any subcommittees thereof. Any such body in carrying out these functions shall be a peer review committee as defined in Section 31-7-15 Official Code of Georgia Annotated (O.C.G.A) and shall be entitled to the protection and rights afforded to the proceedings and members of a peer review committee by the laws of the State of Georgia and the United States.

Section 2. Peer Review Groups

In carrying out peer review functions, the various clinical services and committees established under these Bylaws and the Rules and Regulations and any subcommittee thereof will evaluate the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital utilization review, medical audit, ambulatory care review, claims review, underwriting assistance and the compliance by Georgia Regents AU Medical Center and/or the Children’s Hospital of Georgia with standards set by accrediting organizations, associations of health care providers and applicable laws, rules and regulations. While engaged in these peer review activities, the clinical services committees and any subcommittees thereof shall be acting as Review Organizations as that term is defined in Section 31-7-131 O.C.G.A. and the proceedings thereof and the members thereof shall be entitled to the rights and protection afforded by the laws of the State of Georgia and the United States.

Section 3. Medical Review Committee

In carrying out peer review functions, including focused review activities, the various clinical services and committees established under these Bylaws and the Rules and Regulations and subcommittees thereof will evaluate and make recommendations. These recommendations are to improve the quality of health care rendered by providers or to determine that health services rendered were professionally indicated or performed in compliance with its applicable standard of care or determine that the cost of health care rendered was considered reasonable by the providers of professional health services in the area. While engaged in these activities, the clinical services committees and any subcommittees thereof will be acting as a medical review committee as that term is defined in Section 31-7-140 O.C.G.A and the proceedings thereof and the members thereof shall be entitled to the rights and protection afforded by the laws of the State of Georgia and the United States.

Section 4. Professional Peer Review Body

Each committee and each clinical service of the Medical Staff shall be a Peer Review Body when such committee or clinical service is performing a professional review activity, a focused review and evaluation of a practitioner’s performance, or is assisting the Board of Directors or Executive Committee in performing a professional review activity for purposes of the Health Care Quality Improvement Act of 1986. Such focused reviews shall be carried out pursuant to MCGHI-AUMC policy.

ARTICLE XIII - AMENDMENTS

These Bylaws may be amended. Proposed amendments if made by the Bylaws Committee pursuant to Article IX, Section 11 hereof may be presented by the Bylaws Committee to a Medical Staff meeting.
Proposed amendments to these Bylaws not made by the Bylaws Committee shall be referred to the Bylaws Committee, which shall report thereon at the next meeting of the Medical Staff. A copy of any proposed amendment to these Bylaws shall be enclosed with the notice of the Medical Staff meeting at which it is to be considered. Adoption of a proposed amendment to these Bylaws shall require a two-thirds majority vote of those Active Medical Staff members voting on the amendment either at a duly held meeting of the Medical Staff or by electronic vote. Amendments so made shall not become effective until they are approved by the Board of Directors.

**ARTICLE XIV - ADOPTION**

These Bylaws may be adopted at any duly held meeting of the Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Board of Directors. Neither body may unilaterally amend the Medical Staff Bylaws and Rules and Regulations. Adoption of the Bylaws requires a two-thirds majority vote of those Active Medical Staff members on such adoption voting at either a duly held meeting of the Medical Staff or by electronic vote. They shall, when adopted and approved, be equally binding on the Board of Directors and the Medical Staff. These Medical Bylaws and Rules and Regulations are not intended to conflict with bylaws of MCGHI AUMC. In the event of such a conflict the bylaws of MCGHI AUMC shall control. Copies of amended Bylaws and Rules and Regulations shall be distributed to Medical Staff members and Practitioners with Clinical Privileges.

Proposed and recommended by the Medical Staff of the Georgia Regents AU Health System, MCG Health, Inc. AU Medical Center on the 2nd day of December 2015.

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Walter Pipkin, MD
President, Georgia Regents AU Medical Center Medical Staff

Kevin C. Dellsperger, M.D., PhD
VP and Chief Medical Officer
Georgia Regents AU Medical Center

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Approved this 28th day of January 2016 by the Board of Directors, Georgia Regents AU Health System to take effect on 29th day of January 2016

Peter Buckley, MD
Interim CEO, Georgia Regents AU Medical Center and Medical Associates
Interim EVP for Health Affairs

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Brooks Keel, PhD President, Augusta University CEO, Georgia Regents AU Health System